

## SMRH Service Request Form

Consumer Information	
Consumer Name:	Birth Date:
Street Address:	City:
County:	Zip Code:
Medicaid Number:	SSN:
Phone Number:	
Developmental Disability Diagnosis:	
Level of Mental Retardation: <div style="display: flex; justify-content: space-around; align-items: center;"> <input type="checkbox"/> Severe             <input type="checkbox"/> Profound             <input type="checkbox"/> Moderate             <input type="checkbox"/> Mild             <input type="checkbox"/> Borderline             <input type="checkbox"/> N/A           </div>	
Does the person have a current mental health diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mental Health Diagnosis:	
Does the person have a current Person Centered Plan (PCP)? <input type="checkbox"/> Yes <input type="checkbox"/> No PCP Date:	
Does the person have an HCBS Plan of Care? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Current Medications, Dosage/Frequency and Purpose:	
Medical Issues:	
Current placement and history of previous placements:	
Has he/she hurt someone? <input type="checkbox"/> Yes <input type="checkbox"/> No    Has he/she hurt self? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Parent/Guardian Information	
Parent/Guardian Name:	
Street Address:	City:
County:	Zip Code:
Phone Number:	Mobile Number:
E-Mail:	

Agency Information		
Is a Community Developmental Disabilities Organization (CDDO) involved? <input type="checkbox"/> Yes <input type="checkbox"/> No		
CDDO:		
Is there a current Developmental Disability Profile (DDP) or BASIS? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Community Service Provider:		
Case Manager's Name:		
Street Address:	City:	Zip Code:
1 <sup>st</sup> Phone Number:		2 <sup>nd</sup> Phone Number:
Fax Number:		E-Mail:
Date QEC was contacted by CDDO:		Fax Number:
QEC Name:		E-Mail:
Phone Number:		
Is the individual currently receiving mental health services? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Other mental health services:		
CMHC:		
CMHC Case Manager:		
Person Making Contact		
Contact Name:		Phone Number:
Affiliation:		
Agency requested:	<input type="checkbox"/> KNI	<input type="checkbox"/> PSH&TC
Requested service(s) (one or more):		
<input type="checkbox"/> Admission <input type="checkbox"/> Behavioral/Psychiatric Consultation <input type="checkbox"/> Dental		
<input type="checkbox"/> Emergency Respite Care <input type="checkbox"/> Medical Consultation		
<input type="checkbox"/> Outpatient Sex Offender Treatment Consultation (PSH&TC)		
DDT&TS/Outreach services: <input type="checkbox"/> Inpatient <input type="checkbox"/> Training		
Evaluation/Assessment:		
<input type="checkbox"/> Medication <input type="checkbox"/> OT/PT/Adaptive Equipment		
<input type="checkbox"/> Psychological <input type="checkbox"/> Speech/Hearing		
<input type="checkbox"/> Other service(s) requested:		
Notes on service(s) requested:		
Date of Request:		

# DUAL DIAGNOSIS TREATMENT & TRAINING SERVICES

## PARSONS STATE HOSPITAL & TRAINING CENTER

Person being served:

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Where does the person live? Please check one of the following:

- |  |   |
|--|---|
| <input type="checkbox"/> At home with immediate family | <input type="checkbox"/> By him/herself                           |
| <input type="checkbox"/> At home with a foster family  | <input type="checkbox"/> In a home with 8 or fewer residents      |
| <input type="checkbox"/> At home with a relative       | <input type="checkbox"/> In a facility with more than 8 residents |

Other: \_\_\_\_\_

### DEVELOPMENTAL DISABILITIES AGENCY INFORMATION

Developmental Disability: \_\_\_\_\_

Tier Level: \_\_\_\_\_

Community Developmental Disabilities Organization (CDDO):

\_\_\_\_\_

Community Support Provider (CSP) Information:

Agency(ies) \_\_\_\_\_

Day Services: \_\_\_\_\_

Residential Services: \_\_\_\_\_

Developmental Disabilities Case manager: \_\_\_\_\_

Case manager's office address: \_\_\_\_\_

City

Zip

Case manager's phone number: \_\_\_\_\_

Case manager's mobile phone number: \_\_\_\_\_

Case manager's email address: \_\_\_\_\_

### MENTAL HEALTH AGENCY INFORMATION

Is the individual currently receiving mental health services? ☐ Yes ☐ No

Psychiatrist: \_\_\_\_\_

Community Mental Health Center (CMHC) information, if utilized:

CMHC \_\_\_\_\_

\_\_\_\_\_

Street Address

City

Zip

CMHC phone number: \_\_\_\_\_

CMHC mobile phone number: \_\_\_\_\_

Mental Health (MH) Therapist: \_\_\_\_\_

MH Case manager: \_\_\_\_\_

## ***Mental Health Diagnoses***

*Please list only the current mental health diagnosis*

*Diagnosis*

*Age of Onset if known*


### **Hospitalizations**

Has the person ever been hospitalized *for behavioral or emotional problems*?

☐ No

☐ Yes      If yes, please provide the hospital name and the admission and discharge dates for each.

<u>Hospital</u>	<u>Admission Date</u>	<u>Discharge Date</u>

## **SCHOOL INFORMATION**

Is the person CURRENTLY in school?    ☐ Yes      ☐ No

Highest grade this person has completed. \_\_\_\_\_

Does this person currently have behavioral problems at school?

☐ Yes

☐ No

Would you like an outreach consultant to work with your child's school?

☐ Yes

☐ No

Name of Teacher \_\_\_\_\_

Name of School \_\_\_\_\_

School Address \_\_\_\_\_ School Phone \_\_\_\_\_

## **BEHAVIORAL INFORMATION**

Has a behavioral specialist been consulted prior to today?    ☐ Yes    ☐ No

If yes, please indicate the type of practitioner providing behavioral consultation.

☐ Psychologist

☐ Autism Specialist

☐ School Behavioral Consultant

☐ Behavioral Analyst

☐ Positive Behavior Supports Specialist

☐ Other

Please indicate whether this individual has been involved with any of the following in the **past 3 months**

- |                                      | Yes                      | No                       |
|--------------------------------------|--------------------------|--------------------------|
| 1. The Judicial system               | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Social Services                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Inpatient Mental Health Treatment | <input type="checkbox"/> | <input type="checkbox"/> |

Has this person previously received services from DDT&TS

☐

☐

If yes, please provide the date(s) for previous consultations

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**In the Past THREE Months (ONLY):**

1. Did the person injure him/herself? For example, did the person bite him/herself, insert items into body cavities or into the skin, bang his/her head on the wall or floor, etc.? ☐ Yes ☐ No
2. Did the person hit, scratch, kick, bite, or otherwise physically attack others? ☐ Yes ☐ No
3. Did the person display behaviors such as screaming, crying, tipping over furniture, knocking materials to the floor, etc.? ☐ Yes ☐ No
4. Did the person destroy or damage property (i.e., breaking windows, throwing furniture, tearing up clothing, etc.)? ☐ Yes ☐ No
5. Did the person demonstrate noncompliance? ☐ Yes ☐ No
6. Was the person verbally aggressive against others? ☐ Yes ☐ No

How often do these behaviors currently occur? ☐ Hourly ☐ Daily  
☐ Weekly ☐ Monthly or less often

How severe are the behaviors? ☐ Mild: disruptive with little risk to property or health  
☐ Moderate: property damage or minor injury  
☐ Severe: significant threat to health or safety

Situations in which behavior is most likely to occur:

Days/Times \_\_\_\_\_

Settings/Activities \_\_\_\_\_

Persons Present \_\_\_\_\_

What usually happens right Before the behavior?

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What usually happens right After the behavior?

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*Please return all documents to the Admissions Coordinator, Karen VanLeeuwin at fax no: 620.423.0419*

*or*

*Director of Dual Diagnosis Treatment and Training Services, Dr. Renee' Patrick at fax no: 620.421.1499*

**Parsons State Hospital & Training Center**  
**Dual Diagnosis Treatment & Training Services**  
**2601 Gabriel Avenue, PO Box 738**  
**Parsons, KS 67357-0738**

Ph: (620) 421-6550 x1695 Main Fax: (620) 421-3623 DDT&TS Fax: (620) 421-1499

**I authorize the release of information for/to Parsons State Hospital & Training Center/Dual Diagnosis Treatment & Training Services:**

NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ SSN \_\_\_\_\_

☐ TO ☐ FROM      The following Agency/Individual:

Name	Position/Relationship	Phone
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Agency	Street Address
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City	State	Zip	Fax
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<p>Information is to include: All medical, social, psychological, behavioral, educational, psychiatric and other pertinent information <b>OR</b> <input type="checkbox"/> Medical    <input type="checkbox"/> Social    <input type="checkbox"/> School <input type="checkbox"/> Special Education    <input type="checkbox"/> Behavioral <input type="checkbox"/> Psychological    <input type="checkbox"/> Psychiatric <input type="checkbox"/> Other _____</p>	<p>Information is to be used for:</p> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> Placement purposes</div><div><input type="checkbox"/> Treatment planning</div></div> <div><input type="checkbox"/> Consultation and recommendations</div> <div><input type="checkbox"/> To assist with legal proceedings</div> <div><input type="checkbox"/> To assist others in planning/providing services</div> <div><input type="checkbox"/> Educational planning/placement</div> <div><input type="checkbox"/> Other _____</div>
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This Authorization expires on \_\_\_\_\_.  
If left blank authorization will expire 30 days after the case is closed.

_____ Signature of Client	_____ Date
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_____ Signature of Parent/Guardian      (relationship)	_____ Date
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_____ Signature of Witness	_____ Date
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**Consent will not be considered valid without a witness' signature and a client or parent/guardian signature. A public notary is not necessary.** I understand that I am not required to sign this release, and if signed, I may revoke it at any time, except to the extent that is required by law. To revoke this authorization, I may contact PSH&TC in writing. I understand that PSH&TC cannot require a signed release as a condition of services unless permitted by law. I have the right to inspect or copy any consultation recommendations provided by PSH&TC. I understand that records obtained by PSH&TC may include HIV, psychiatric, alcohol, or drug abuse information. Information gathered by PSH&TC may include psychological and behavioral information. This information may be protected by State and Federal laws and regulations. I understand that if the information is collected by someone who is not a health care provider it may be re-disclosed and is no longer protected by privacy regulations. I hereby release and discharge PSH&TC/indicated Agency and the person or entity to or from which the above information is provided/received and their employees from any liability for the release of any information disclosed pursuant to this authorization. **Form updated: 11/9/11**

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CONSENT FOR VIDEOTAPING

I/we authorize Parsons State Hospital/Dual Diagnosis Treatment & Training Services (DDT&TS) to videotape my son/daughter/ward/self \_\_\_\_\_ as deemed necessary to evaluate behavior(s). This tape will be used for evaluation and training (e.g., in-servicing staff, presentations, etc.) purposes only. I understand that I have the right to withdraw this consent at any time and that I have the right to view any videotape made of my son/daughter/ward. I understand that the videotapes may be kept for future reference by the DDT&TS team following the consultation, but will not be released to anyone without my express written consent to release any videotape(s).

This consent will expire on \_\_\_\_\_

If left blank, this consent will expire 30 days after the case is closed except as indicated above.

\_\_\_\_\_  
Client/Consumer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**NOTE: Consent will not be considered valid without a witness' signature and a client or parent/guardian signature.**

**Form updated: 11/9/11**

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**CONSENT FOR EVALUATION AND TREATMENT**

I/we grant permission for Parsons State Hospital and Training Center / Dual Diagnosis Treatment & Training Services (DDT&TS) team to complete a full evaluation of my son/daughter/ward/self, \_\_\_\_\_, which may include any or all of the following: observe; share information; review records, make behavior support recommendations; and, if necessary, pilot various behavior support strategies.

I realize when behavior supports are initiated there is the possibility of a temporary (i.e., few days or weeks) of increased or worsening of behaviors for which my son/daughter/ward was referred. I understand that all of the information regarding the evaluation will remain confidential.

This consent will remain in effect until it is expressly revoked in writing or until one year from the date signed, whichever occurs first.

\_\_\_\_\_  
Client/Consumer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**NOTE: Consent will not be considered valid without a witness' signature and a client or parent/guardian signature.**

**Form updated: 11/9/11**

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**Informed Consent/Assent to Allow Environmental Manipulations Procedures by  
the DDT&TS Outreach Consultation Team**

I/we grant permission for the Dual Diagnosis Treatment & Training Services (DDT&TS) team to conduct environmental manipulations of the behavioral antecedents and consequences (Functional Behavior Analysis) for behavior exhibited by my son/daughter/ward/self, \_\_\_\_\_.

I understand that I may revoke this consent at any time. The behavioral antecedents and consequences of my son/daughter/ward's behavior are being manipulated so that the DDT&TS Outreach personnel can better determine the causes of behavior resulting in a referral for services. An additional purpose for these procedures is to provide the community support team with recommendations for behavioral planning that will likely lead to increased successful community living. I understand that manipulations of the antecedents and consequences of aberrant behavior can result in a temporary increase in those behaviors. I understand that the DDT&TS Outreach personnel conducting these manipulations will provide agency staff with training so that staff can be involved in this process. I further understand that these manipulations will not take place without a detailed outline provided in writing to the requesting agency and the parent/guardian (if applicable). This consent will remain in effect until it is expressly revoked or until one year from the date signed, whichever occurs first.

\_\_\_\_\_  
Client/ Consumer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agency Personnel

\_\_\_\_\_  
Position

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**NOTE: Consent will not be considered valid without a witness' signature and a client or parent/guardian signature.**

**Form updated 11/9/11**

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**CONSENT FOR Email**

I/we authorize the Dual Diagnosis Treatment & Training Services (DDT&TS) to communicate with community support team members about my son/daughter/ward/self \_\_\_\_\_ via electronic mail/communication service. I understand that this communication cannot be guaranteed to be secure.

**RISKS ASSOCIATED WITH EMAIL**

Some, but not all, of the risks with email are listed here:

- Email can be immediately broadcast worldwide and received by many intended and unintended recipients;
- Email senders can easily misaddress an email;
- Email is easier to falsify than handwritten or signed documents;
- Backup copies of email may exist even after the sender or recipient has deleted his or her copy;
- Employers and on-line services have a right to archive and inspect emails transmitted through their systems;
- Email can be intercepted, altered, forwarded, or used without authorization or detection;
- Email can be used to introduce system computer viruses; and
- Email can be used as evidence in court.

I understand these risks and agree to allow the use of email for communication purposes. Should I change my email address, I will notify DDT&TS. Should I decide to revoke consent for email communication, I will send written revocation by postal mail.

This consent will expire on \_\_\_\_\_.

If left blank, this consent will expire 30 days after the case is closed.

\_\_\_\_\_  
Client/Consumer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**NOTE: Consent will not be considered valid without a witness' signature and a client or parent/guardian signature.**

**Form updated: 11/9/11**